Removing erroneous disease codes from the GP record

Background

When disease registers are cleaned, a proportion of patients (typically between 2-5%) are found *not* to have that condition - they have erroneous codes in their record.

These are typically isolated single codes without any other supporting information, though sometimes the situation can be complex, where patients with similar names have had incorrect information added.

Erroneous codes may have been added by a keystroke mistake, or where someone with chest pain, for example, may have been coded with MI when on subsequent investigation it wasn't. Similar things happen with most other chronic diseases. Another example is a patient who has erroneously had "dementia" added to their record – they have seen this and demanded its removal.

People who are erroneously included in a disease register "dilute" performance targets because treatment is inappropriate. The patient may also end up with data in their records that could affect things like insurance.

NHS England states:

"If you decide the health or care information in a record is inaccurate and need to amend it, the original entry must not be deleted. It must still be readable. This is because other health and care professionals may have read it and therefore may need to refer to it at a later date to justify their decisions. For paper or handwritten records, you should put a single line through the error, initial it, and put the correct information. Electronic records will vary by system, but all will have an audit trail function, which creates a log of your keystrokes - showing what you typed or added and when. It will also capture any amendments or deletions you make to a record. This is vital to ensure the integrity of the record."

More information: transform.england.nhs.uk/information-governance/guidance/amending-patient-and-service-user-records/

Londonwide Local Medical Committees has similar guidance:

"Where the record contains an opinion, judgement or a provisional diagnosis and that later proves incorrect, this should be noted in a subsequent record entry, but the original entry should not be amended...

When retrospectively adding more detailed notes to the patient's record, the record should include (in a way that is immediately apparent to an objective reader): The name of the person adding the information; The time and date of the addition; An explanation of which information has been added; An explanation of why these were not recorded at the time of the original entry and why they are being entered now."

More information: lmc.org.uk/wp-content/uploads/2022/03/Amending-medical-records-appropriate-circumstances-and-how-it-should-be-done.pdf

CEG recommendation

One solution is to preserve the original code as free text but delete it as a coded item. The original record is then preserved but does not interfere with the patient's care.

1. Carefully review the record to ascertain whether the code has been correctly and appropriately entered.
2. If it is clear that the coded disease is not correct, then the code can be deleted from the record.
3. The following code should then be added: **185981001 Error entry deleted**.
4. Then note the following in the record as free text:
    - The original code and code descriptor, stating it has been deleted.
    - The person amending the record, the date, why they have done this.
5. Consideration should be given to whether the patient is fully aware that they do not have the condition stated – if there is any doubt about this, the patient should be informed.

Example:

A patient is found to have had atrial fibrillation (AF) added to her record 10 years ago on a routine search for people on anticoagulants.

The GP can find no other evidence in her medical record that she has AF, either in the electronic record or paper notes/attached letters. There is one letter that says she was investigated 10 years ago in an A&E department for possible AF after she fainted and the ECG was normal.

The AF code is deleted from her record.

In the consultation relevant to that entry, Dr Alwyn Smith typed their name and date and stated that the electronic code "49436004 |Atrial fibrillation (disorder)|" had been deleted because it was incorrect following a detailed review of the record.

The GP knows the patient and has seen her recently and neither the GP nor patient have ever considered she has AF, so the GP does not feel they need to inform the patient in this instance.